

[Current Date]

[Patient Name]

[Patient Address]

[City, State, Zip Code]

Re: Follow-up on Medical Records Release Request

Dear [Patient Name],

We are writing to you regarding your recent request to release your medical records. Upon reviewing your submission, we noticed that the Authorization to Release Information form was returned without a signature.

To comply with HIPAA regulations and protect your privacy, we cannot process your request or transfer any files until we have a signed and dated authorization on file.

Please find the following options to complete this request:

- Sign the attached copy of the form and mail it back to us in the provided envelope.
- Visit our clinic in person to sign the document at the front desk.
- Fax the signed document to [Clinic Fax Number].

Once we receive the signed authorization, your records will be processed within [Number] business days.

If you have any questions, please contact the Medical Records Department at [Clinic Phone Number].

Sincerely,

[Your Name/Department]

[Clinic Name]

[Clinic Phone Number]